KMCWC HemOnc Department Analysis February 1997 through July 31, 2001

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- Procedures Billed and Paid by Procedure Type
- Payments By Private Third Party Payors
 - Payments By Medicaid/MedQuest
- Payments By Medicare/TriCare - 26 4 4 6 6
- Payments By Payor Type Summary

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KMCWC HemOnc Department **Summary of Findings** February 1997 to September 1, 1999

Summary

An analysis of select patient files and related billing data for Hematology/Oncology ("HemOnc") Physicians was conducted on August 14, 2001. The review focused on the following four invasive procedures:

- 1. 62270 (Spinal puncture, Jumbar, diagnostic)
- 2. 85095 (Bone marrow; aspiration only).
- 3. 85102 (Bone marrow biopsy, needle or trocar)
- 4. 96450 (Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including lumbar puncture).

The procedures analyzed were all performed at Kapi olani Medical Center for Women & Children ("KMCWC"). The Pediatric Ambulatory Unit ("PAU") is a department of the hospital. Most procedures are performed in a treatment room on the PAU unit. The hospital employs a Nurse Practitioner ("NP"). The NP performs procedures as well.

The purpose of the analysis was to determine who performed each procedure, based on medical record documentation, and to assess whether the procedure should have been billed by the physician and paid based on the current Medicare regulations. The methodology employed, findings, and monetary impact of items found in error are detailed in the body of this report.

Deloitte & Touche ("D&T") was retained by Kapi olani's ("KH") outside counsel, Dennis M. Warren, to perform the work described in this document. All work associated with this project was undertaken at the direction of Mr. Warren and/or Kapiolani's General Counsel, Sharon On Leng, working in concert with Mr. Warren.

Methodology

Objective

The analysis was performed to evaluate whether medical record documentation by HemOnc physicians for procedures submitted to government payers was compliant with Medicare Regulations.

Sampling Unit

The sampling unit used for this analysis was a paid claim that contained any/or some combination of four CPT codes as identified above.

Claims Population

The population included paid claims for procedures billed by HemOnc physicians between February 1997 and September 1, 1999. This time frame represents the period from which Kapi olani Medical Specialists ("KMS"), a subsidiary of KH, began billing for HemOnc professional services until the point in time that KMS management implemented an organizational change effective September 1, 1999. In the first quarter of 1999, KMS management began providing education and guidance to HemOnc physicians regarding procedure performance and documentation standards as set forth in Medicare regulations. In addition, the billing office implemented a 100% review policy effective September 1, 1999 such that documentation for every service submitted for billing was examined by a coder prior to claims processing.

Sampling Frame

Electronic billing files were provided to D&T by KMS for the period under analysis. The electronic files contained patient/medical record numbers (to assist in locating the chart), date of service, medical provider number, procedure code, and diagnostic information. The files were summarized by payer and procedure code. When only government payers were selected, a total of 62 claims were identified. These 62 claims were found to constitute a full sample for the time period.

Sources of Data

D&T obtained and read the following documents in order to complete this analysis:

- Medical Record documentation including the PAU record, anesthesia record, and physician orders. The PAU unit utilizes a multi-disciplinary record on which both physicians and nurses document all care provided to a patient for a given date of service. Procedures performed are documented on this record.
- Superbill indicating the services performed. The physician chooses the level of E/M service provided and indicates procedures performed.
- HCFA-1500
- Remittance Advice

Analysis Protocol

D&T utilized the following Medicare Regulations in cases where a procedure was performed by the NP it would be considered inappropriately billed:

Medicare Carriers Manual §2050. Incident to Physician's Professional Services states that certain criteria must be met in order to bill services incident to. We identified two criteria that were not met.

- 1. "For hospital patients, there is no Medicare coverage of the services of physicianemployed auxiliary personnel as services incident to physicians' services under §1861(s)(2)(A) of the Social Security Act."
- 2. At §2050.1C the regulation goes on to state, "Employment. -- To be considered an employee for purposes of this section, the nonphysician performing an incident to service may be a part-time, full-time, or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician (hereafter referred to collectively as the physician or other entity) who provides direct personal supervision (as described below)."

Since all services are performed in the hospital setting, there is no coverage. The HemOnc physicians do not employ the NP. It was determined that these regulatory provisions did not apply to the PAU unit and as a result, any service performed, all or in part, by the NP would not be billable.

When analyzing services the one service provided by a resident and billed by the teaching physician, D&T utilized the following regulation.

Medicare Carriers Manual §15016, Supervising Physicians in Teaching Settings, "In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure!

Claims were determined to be in error if the billed procedures were documented as:

- 1. Performed by a NP with either no documented attending physician supervision and/or no physician documentation;
- 2. Performed by a resident with either no documented attending physician supervision and/or no physician documentation; or
- 3. Performed by the attending physician with no physician documentation.

Findings

For purposes of analyzing each claim we determined who performed the procedure, what record was relied upon in making this determination, and whether the procedure should have been billed and paid. The following categories of findings were developed:



Procedures Found in Error Based on Documentation	# Of
	Occurrences
1. Unable to Determine Who Performed Procedure: D&T	
was unable to determine who performed the billed	
procedure based on the documentation provided.	11
Essentially there was no documentation to support billing	
for a procedure.	
2. Performed by NP/Physician: The Anesthesia Record	
indicated that both the NP and the HemOnc Physician were	-
present at some time during the procedure. However,	13
because a procedure note was not included in the	
documentation, D&T was unable to determine if the	
physician was present during or personally performed the	
key portion of the procedure.	
3. Performed by NP: D&T determined that the NP performed	
the billed procedure based on the documentation provided.	
Attending supervision was not documented in the patient's	<u>6</u>
medical record. NP was indicated as the performing	
clinician in the PAU Note and/or the Anesthesia Record.	
4. Performed by Resident D&T determined that a Resident	
performed the billed procedure based on the documentation	
provided. Attending supervision was not documented in the	1
medical record. The Resident was indicated as the	Reserved
performing physician in the Anesthesia Record.	
5. Performed by Physician D&T determined that the	
attending physician completed the billed procedure;	ł
however, there was no documentation regarding the	7
procedure completed by the physician included in the	
documentation provided. The performing physician was	
indicated in the PAU Note and/or Anesthesia record.	
Total Procedures Found in Error	38

Monetary Impact

Of the 62 claims for invasive procedures billed to government payers during the time period in question, it was determined that the medical records did not support the procedure billed in 38 instances, representing \$4536.14 in overpayments. Of this figure \$2932.17 was paid by Hawaii Medicaid; and \$1603.97 was paid by the Med-Quest program. The following chart entitled "KMCWC HemOnc Department, Summary of Findings Chart, February 1997 to September 1, 1999" breaks this total figure out by physician, number of procedures paid and the amount of restitution.

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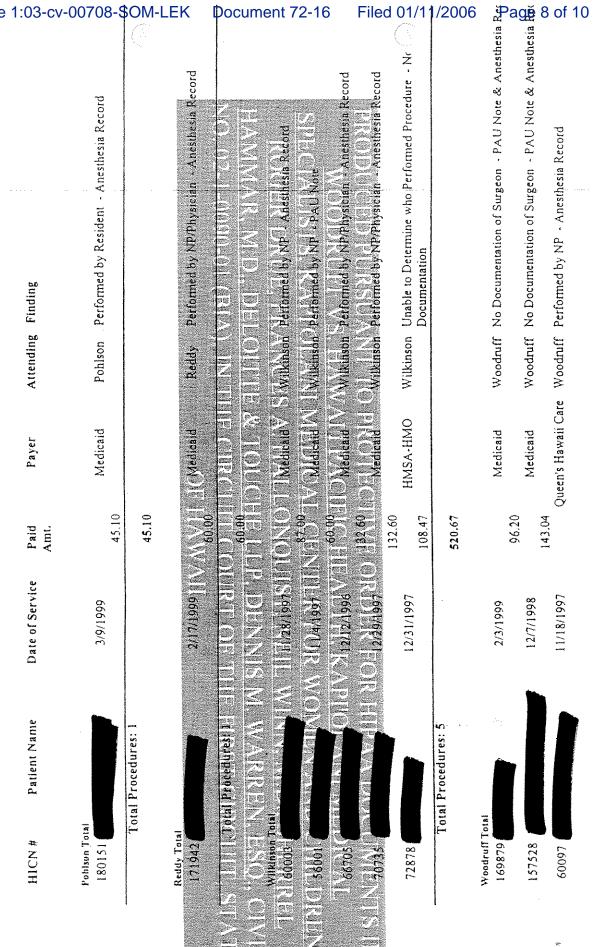
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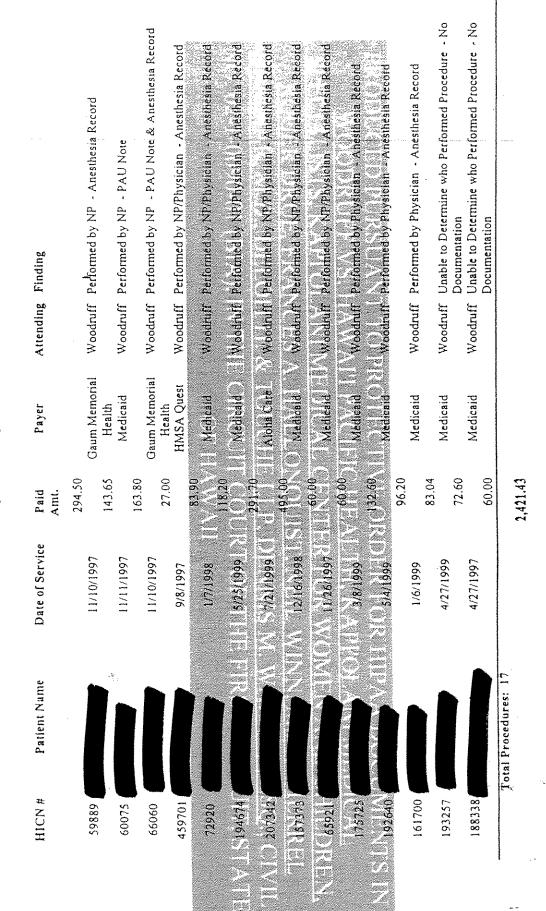


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KMCWC Hen c Department Summary of Findings Chart February 1997 - September 1, 1999



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February 1997 - September 1, 1999 KMCWC HemOnc Department Summary of Findings Chart

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Date of Service	11/6/1997		, dan para da
Patient Name		Total Procedures: 1	Grand Total: 38 Procedures
HICN #	Yamamoto Total 58079	Tot	GF
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